Medical Culture and Health Politics: The Ontario Debate

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ABSTRACT

The 1986 doctors' strike in Ontario brought into stark relief many of the issues that have been latent in Canadian health politics for several decades. In this paper, an analysis from a sociological perspective is offered of the issues involved in the 1986 doctors' strike. Issues are discussed in light of the history of medicare in Canada, the social structure of medicine and its practice in Canada and the political centrality of access to health care as a right. Throughout the paper, health care is defined as a central social concern, basic to environmental health and well-being.

L'Ontario fait face aux problèmes des services médicaux

La grève menée par les médecins de l'Ontario en 1986 a étalé au grand jour plusieurs problèmes touchant la politique canadienne sur les services médicaux qui, pendant bien des années, étaient demeurés dans l'ombre. Le présent article étudie ces problèmes d'un point de vue sociologique et tient compte de l'histoire des services médicaux, de la structure sociale et de la pratique de la médecine au Canada et du droit, reconnu par tous, à l'accès de ces services. Tout au long de cet article, les services médicaux sont décrits comme étant un élément social de haute importance dont dépendent la santé et le bien-être de la population.

The summer of 1986 was a hot one in Ontario. Doctors' offices and the emergency rooms of several hospitals were closed, not by employees demanding a living wage, but by the highest paid professional group in Canada - physicians. Ontarians who had come to rely on universal health care paid for by provincial health insurance, were faced with the frightening spectre of a health care system gone terribly awry. Questions arose about whether health care would be available when needed most.

The front pages of Ontario's newspapers were dominated during the summer by headlines about the doctors' strike. The plight of patients seeking emergency treatment being turned away from hospitals were chronicled. The public witnessed the unlikely spectacle of doctors in white coats picketing at Queen's Park, handing out leaflets from behind a bank of bedpans. Editorialists offered opinions on the dispute and the Ontario Medical Association bought full page advertisements in an attempt to explain its point of view to the public. Yet, what seemed to loom longest in the strike were questions. The public seemed not to understand why such a vital service as health care was being withdrawn by doctors. They had further questions about how this situation had come to be.

The issues involved in the 1986 Ontario doctors' strike are complex indeed. The strike is one event in the long evolution of health care in Canada. It emerged out of historical tensions and assumptions about what the Canadian health system is and ought to be, on the part of the central players. The strike was also a social phenomenon, reflecting the social, economic, political and ideological underpinnings of the practice of medicine in Canada. These aspects, too, have deep historical roots. The strike, as well, highlighted to doctors, politicians and the public, the centrality to Canadians of health care as a right. In this paper, a sociological analysis of the issues involved in and highlighted by the 1986 doctors' strike is offered. Throughout, health care access and quality are seen as basic to personal and environmental well-being of Canadians.

THE EMERGENCE OF HEALTH CARE IN CANADA

Monique Begin, under whose Ministry of Health leadership the pivotal 1984 Canada Health Act was passed, has suggested that "Canada is the Sweden of the Americas" (Begin, 1986:79). By this, she means that Canada's level of "safety-net" social programs is more developed than in the United States. In particular,

Canada legislated universal government-sponsored health insurance in 1966 (Naylor, 1982:12). It came into effect in 1968 and has operated with full provincial participation since 1971 (Naylor, 1982:12). The idea behind Canadian government health insurance is "the elimination of financial barriers to health care" (Marmor, 1986:444).

Although the Canadian health care system is viewed by some, most notably by those in the United States, as an example or a model of what Americans term "socialized medicine" (Begin, 1986:80; Marmor, 1986:444), this perception indicates more about the differences in political culture between the two countries than it does anything about the Canadian health care system. Relative to most capitalist countries, with the U.S. as the exception, state involvement in financing personal health care in Canada came late (Swartz, 1987:571). Hospital insurance was only provided in 1958 and medical insurance not until a decade later (Swartz, 1987:571). It should be noted with some interest, however, that the Canadian Medical Association (CMA) had proposed a plan for health insurance as early as 1934 that would be administered by provincial health departments and remove economic barriers between doctors and patients (Begin, 1986:86; Naylor, 1986). Even at this early date, the CMA argued for the right to bill wealthier patients higher fees. In a 1944 Gallup poll, 80 percent of Canadians favoured a comprehensive health care plan (Taylor, 1987:73). In contrast to Canada's relatively late arrival on the health insurance front, Britain has had National Health Insurance since the end of World War II, with Sweden and many countries in Western Europe also having early programs.

In Canada, health insurance emerged out of the problems faced by industrial workers in gaining access to health care (Swartz, 1987:572), although the commonly held image is that health insurance was first introduced by the Saskatchewan CCF-NDP government in 1960 after the famous Medicare Election. This view accounts for the popular misperception that health insurance resulted from progressive legislation introduced over the vocal opposition of doctors. The realities of the emergence of health insurance and relevance to today's situation, tend to be obscured by this misunderstanding of the roots of Canadian medicare.

Initially, health insurance was provided to workers as a fringe benefit seen by employers largely as a way of increasing the efficiency of this labour force, or as a political benefit to ward off worker unrest (Swartz, 1987:572). But this form of employer welfare can increase the costs of products as well as militancy among workers who reject employer paternalism. It also was unavailable to the poor who were subjected to "charity" medicare. Thus, state involvement in health insurance became the means of *containing* industrial unrest and the possibility of workers turning to socialism. Rather than health insurance being a socialist program, it seems that it was designed in Canada to stem the movement toward socialism during the Depression and the forties when growing militancy among workers was a reality. W.L. Mackenzie King well understood this when he wrote:

> Social insurance, which in reality is health insurance in one form or another, is a means employed in most industrial countries to bring about a wider measure of social justice, without, on one hand, disturbing the institution of private property and its advantages to the Community, or, on the other, imperilling the thrift and industry of individuals. (King, 1918:222).

It is not surprising then, that it was British Columbia, the province with the longest history in Canada of worker militancy and communist/socialist strength in its labour movement, that first introduced public health insurance in 1935 (Swartz, 1987:573; Naylor, 1986), in the face of growing radicalization among the unemployed and a CCF opposition that represented one-third of voters. The legislation, passed by the B.C. legislature and supported by a public referendum, was not enacted, however. The medical profession supported the introduction of health insurance, but only among the unemployed and the very poorest of workers. Business generally supported it but feared the costs in an already shaky provincial financial situation. This led the government to the unworkable compromise of excluding the unemployed, thus alienating the doctors and failing to pacify employers' concerns about costs. Ultimately, the legislation was stalemated after being passed in the legislature.

The B.C. experience, however, was not futile in that it set in motion the mechanisms by which universal health insurance was eventually established many years later. For example, the case for Canada-wide health insurance was made by Grauer in a report for the 1938 Royal Commission on Dominion-Provincial Relation (Swartz, 1986:573). The B.C. Liberal, Ian Mackenzie, who went to Ottawa to join the King cabinet in 1939, began to push for a federal program of health insurance. A number of strikes during the early 1940's reinforced King's fears about industrial radicalism and spurred him to consider health insurance more seriously. The CCF won 34 seats in Ontario in the election of 1943. Thus, by 1943, a federal government committee headed by the Deputy Minister of Health, Dr. J. Heagerty, worked with the Canadian Medical Association to develop a model health insurance bill. Costs and political finagling prevented imple-

mentation once again, but the groundwork for health insurance was in place many years before the Saskatchewan election of 1960.

In British Columbia and Saskatchewan where the CCF had some sway, the health insurance idea was kept alive. In 1949, an inadequate hospital insurance scheme was enacted in British Columbia. The CCF election victory in 1944 led to a government with health insurance as its most important planned reform. By 1947, after backing down from a plan to salary all doctors in Saskatchewan, the CCF government introduced a successful hospital insurance plan and in 1950, health insurance for pensioners. In 1955, health insurance was on the agenda of a federal-provincial conference at which the Premier of Ontario, Leslie Frost, under pressure from the unions, announced Ontario's interest in government hospital insurance. The newly formed Canadian Labour Congress declared its number one goal as being the establishment of government introduced universal hospital insurance. By 1960, a consensus had emerged, largely through the efforts of Mitchell Sharp at a conference on Liberal policy, that the federal government was committed to universal health insurance.

THE 1962 SASKATCHEWAN STRIKE

In Saskatchewan meantime, Tommy Douglas who had been Premier of Saskatchewan since 1954, won re-election in 1960 on the campaign that medical care ought to not have a price tag. Despite the prevalent belief in Canada that medicare began with this election, it is clear that Douglas was one of many who for some time in Canada saw universal health insurance as politically important. The Douglas government saw the new legislation on health insurance as "merely" an extension of its long-term health policies and of a program that was already widespread, including a municipal doctor scheme, an experimental medical plan in one region of the province, and Canada's first hospital insurance plan to cover everyone in a province (Badgley and Wolfe, 1967:5). However, the medical profession was immediately opposed when the program was announced in 1959 and its opposition grew into a much publicized 23 day strike in the summer of 1962. Analysis of the central issues involved in the 1962 strike seems important to understanding the evolution of medicare in Canada, particularly since the medical profession had previously supported health insurance at various points. Understanding of the 1962 Saskatchewan doctors' strike is, of course, relevant to any analysis of the 1986 Ontario doctors' strike.

The 1962 Saskatchewan strike was not the first doctors' strike to occur in Canada. The first took place in 1933-34 in Winnipeg when doctors who were not compensated for treating the poor, refused to provide anything but emergency services to the indigent (Naylor, 1986). Winnipeg officials finally agreed to implement a municipal medical relief program which provided health care to the poor free of charge and compensated the doctors. In 1962 in Saskatchewan, however, the issues involved were quite different.

The medical profession that had pushed for government involvement in health insurance and struck earlier over issues of non-payment, now found itself against the proposal for provincial medicare in Saskatchewan in the late 1950's. What accounts for this? A number of factors emerge as important. Doctors felt excluded from the government's plans to implement medicare. For example, a 1959 committee charged with drafting proposals for the program was comprised of senior civil servants and planners, with no practising physicians as members (Badgley and Wolfe, 1967:24). This feeling of exclusion had long roots as the President of the Saskatchewan Medical Association commented in 1944, "The Health Insurance Bill was a bombshell to us....it was foisted on us without notice....we were not consulted in this, in fact our concern was resented" (Badgley and Wolfe, 1967:26). Despite this difficulty, by 1951, relations between the Douglas government and the medical associations were again cordial, with Dr. J.F.C. Anderson, then President of the Canadian Medical Association, praising Tommy Douglas for his performance as Minister of Health in Saskatchewan (Badgley and Wolfe, 1967:27).

During the 1951-59 period, a number of developments set the stage for the 1962 doctors' strike. In the absence of a comprehensive government health insurance scheme, doctors had begun their own insurance plans, covering up to 40 percent of the population by 1959 (Badgley and Wolfe, 1967:27). Tensions increased between the medical people and the government as the government cutback on assistance to the poor, thereby undercutting the doctors' insurance attempts. The doctors felt hamstrung in their efforts. At the same time, the ranks of doctors in Saskatchewan were changing to include greater numbers of immigrants, many from Great Britain who were adamantly opposed to the implementation of its National Health Service after World War II. Doctors began to cluster more and more in Saskatchewan's cities where they were more distant from rural people and more open to influence by members of their own profession. At the same time, doctors practising in Saskatoon felt concerned about the establishment of University Hospital in the early 1950's. Their worry was competition from new professionals being brought in to staff the medical school. The issues grew into a threatened boycott of the medical school and the new hospital by local doctors in 1954-55 (Badgley and Wolfe, 1967:29), a situation not well handled

by the government.

By the 1960 medicare election, the medical association of Saskatchewan was well organized and even had a "war chest" of funds for its public relations campaign against the government. The ideological issues brought out and paraded as "state-controlled medicine," became the rallying cry of the doctors. The personal relationship of doctor and patient was said to be threatened by government health insurance (Badgley and Wolfe, 1967:32-34; Bitter Medicine 1, National Film Board). The compulsory aspects of the government proposal for health insurance evoked images of "jack boots and barbed wire" for some doctors and opponents. Doctors, such as Alexander Robertson who was Chairman of the University's Department of Social and Preventive Medicine, were removed from executive office on the medical association because of favouring the government's proposal (Badgley and Wolfe, 1967:34). An advertisement appeared in several Saskatchewan newspapers the day before the 1960 election summarizing the doctors' concerns that "compulsory state medicare" would lead to poor quality health care. They emphasized, however, that they were not opposed to prepaid medical insurance. Interestingly, they reassured patients in this advertisement that they would always be available to attend the sick (Badgley and Wolfe, 1967:344-35). On 1 July 1962, 90 percent of doctors' offices were closed. Only emergencies were treated. The government had been returned to power with an increased majority in 1960. The doctors steadfastly refused to negotiate despite their longstanding support of their associations for government involvement in health insurance.

Several conclusions about the now famous 1962 doctors' strike in Saskatchewan seem important to emphasize in light of the 1986 Ontario strike and the continuing struggle by doctors and politicians over Canadian health care. These sociological conclusions can be drawn without assessing blame, but to glean something about the social dynamics involved in the conflict. The conclusions drawn here centre on five themes: who know best, control, ideology, power, and focus. The question of who knows best was central to the 1962 dispute. Government took its mandate on this from its constituents and from expert analysts of the health care system. Medical professionals claimed their expertise from a combination of acquired knowledge through medical school education and their state-sanctioned monopoly over the provision of health care. In terms of control, doctors saw themselves as in charge of health care and resented what they saw as interference from the state. Government, on the other hand, saw itself as in control of public costs of health care and as being in control over public access to health care as a right.

In ideological terms, doctors saw themselves as a high status group with a moral obligation to protect the rights of individuals against incursions by the state. That this ideology was firmly supported by medical "refugees" from the British NHS is clear. Government, in contrast, saw itself as protecting people's rights to health care regardless of their paying capacity. The medical profession felt they had the power in Saskatchewan even two years after the people had voted against them on the medicare issues, to get the government to back down. The government felt it has the power to force the doctors into line without much consultation or compromise. In terms of focus of attention, doctors in 1962 in Saskatchewan seemed more attentive to their own needs than to those of their patients or the people they served. One doctor in an assessment of the strike, for example, focussed entirely on what he called "casualties" to physicians, with no mention of the suffering people may have experienced as a result of the strike (Badgley and Wolfe, 1967:166). The government's attention was focussed on the election and on public opinion to the exclusion of attention to the powerful group of doctors. Needless to say, these themes are by no means separate and have many and multiple overlaps and feedbacks.

One last conclusion about the 1962 Saskatchewan strike looms large in the disputes of the 1980's. In settling the strike in 1962, the medical profession won several concessions including the right to bill patients directly either for the total fee or for an extra fee beyond that provided by provincial health insurance. Doctors also won the right to opt out of the government program if they chose. As Begin suggests, "the compromises reached by the Saskatchewan government in the settlement of the dispute shaped forever the medicare system that Canadians now enjoy from coast to coast" (Begin, 1986:87). The 1964 Hall Commission, on which the national system of health care in Canada rests, called for a universal system publicly administered, comprehensive in coverage, with equal access for all Canadians regardless of income, and without direct charges to patients (Naylor, 1982:12). Fee for service for doctors was endorsed by the Hall Commissioners, but extra-billing was to be banned. In negotiations with the provinces, however, the extra-billing and opting out issue became a point of compromise with some provinces permitting it (Naylor, 1982:13).

THE SOCIAL STRUCTURE OF MEDICAL PRACTICE IN CANADA

To understand the central place of the medical profession in health care and the context in which disputes such as that of 1962 in Saskatchewan and of 1986 in Ontario can occur, it is necessary to explore briefly the

conditions and circumstances under which doctors practice in Canada. Medicare in North America used to be the province of priests or shamans (and still to a limited extent among native people and certain ethnic groups). Intense competition eventually developed among doctors with different orientations. In particular, licensing of what have become known as legitimate medical practitioners, occurred with the founding of the American Medical Association in 1847 by doctors concerned about improving standards of medical training, but also about controlling competition from "irregulars" who had not been trained in similar elite schools (Conrad and Schneider, 1986). At the heart of the founding of medicare as a profession is the control of markets, elimination of competition and the creation of a monopoly over health care (Conrad and Schneider, 1986; Friedson, 1970a:70-73; Friedson, 1970b:209-21).

Medicine is considered a profession *par excellence,* the epitome of a profession (Friedson, 1970b:4; Navarro, 1986:243). This stems from the high regard in which medical practitioners are held in our society, from the control they have over their conditions of work, and from the freedom from competition they enjoy in the practice of their trade. There is little doubt that the foundation of medicine's control over its work is political in character, although it is also premised on some degree of demonstrable expertise and uniform standards of licensure. The medical profession succeeded through political lobbying, in gaining a monopoly over the provision of health care at a time when the status of medical doctors, achieved through recruitment from the upper classes and attending the correct schools, far exceeded their demonstrated capacity to save lives or reduce mortality (Conrad and Schneider, 1986).

Among the most treasured and carefully guarded characteristics of the profession of medicine is its autonomy, paradoxically granted by elected legislators. The state must at some point grant to doctors the right to control the technical side of their work. As long as a profession is free from control by other occupations or professions, its ultimate lack of control from the state which initially grants its autonomy may never be tested. The problem, of course, is that autonomy has its limits in most circumstances. Once the coffers of the state become less beneficent, these limits emerge. Medicine may continue to retain autonomy over the conditions of its work as a profession, but be increasingly asked to justify economic expenditures and social practices in the interest of us all. Thus, in the limits to professional autonomy are sown the seeds of conflict over control of the practice of medicine between the profession and duly elected legislators.

There is a crucial flaw in the granting of autonomy by the state to any profession. By allowing the development of a self-governing, high prestige profession, the image is fostered on the part of both the members of the profession and of the state that the profession can objectively and reliably judge itself, not only on its actual performance, but on its performance in the eyes of society. A problem may be built into the system of self-regulation which encourages members of the profession to deceive themselves as to their objectivity and virtue. They may further be impeded, as a profession, from the development of improved methods of applying the knowledge they gain in the social interest. For example, lay evaluations of medical professionals are prevented by law. There are few limits to professional control once granted by the state. It can easily extend into areas such as social, economic and political dimensions of health care on which doctors are no more expert than others. The limits to professional autonomy thus become almost boundless.

SINCE MEDICARE

By 1971 in Canada all provinces have joined medicare (Taylor, 1987:76). Medicare in Canada has been declared repeatedly by politicians of all political stripes, to be Canada's most successful social program (Bitter Medicine 1, National Film Board; Naylor, 1982; Begin, 1986; Taylor, 1987). Public support of medicare in Canada is such that its discontinuation would not be tolerated. The national health program also had happy consequences for physicians as they were guaranteed an annual income without resorting to collection agencies (Begin, 1986:87). The quality of health services also improved dramatically as new hospitals and new and better medical schools were build and more highly trained allied health care personnel were trained (Taylor, 1987:76-84).

A further discussion of the effects of medicare on physicians' incomes, seems in order since the popular impression, fostered by the media attention given to disputes between doctors and politicians, seems to be that physicians' incomes fell as medicare was implemented. National health insurance increased physicians' incomes in two central ways. First was the reduction or virtual elimination of bad debts by patients. Previously, physicians were successful in Canada in collecting only 60 to 75 percent of outstanding bills (Begin, 1986:86). Physicians also could avoid the fees and time involved in attempting to have their bills paid through collection agencies. Secondly, national health insurance "levelled up" fees which had previously varied enormously by patients' income and private insurance (Marmor, 1986:449). with medicare providing reimbursement for 90 percent of established fees, physicians set their highest rates as the customary billing rate. Thus, physicians' average net earnings in Canada rose dramatically after the introduction of

medicare, and, contrary to popular belief, to a much high level than the average incomes of their American counterparts (Marmor, 1986:451).

During the difficult economic period from 1971 to 1979, doctors' incomes fell in purchasing terms, as did the incomes of most Canadians due to inflation, recessions and other economic problems. Negotiations with some provincial insurance commissions led to improvements in insurance reimbursements to doctors, but the doctors remained unsatisfied. More and more doctors began to extra-bill patients to make up the difference. Few provinces formally approved of the practice, Alberta and Nova Scotia being the exceptions, but ambiguity about the practice was built into the medicare program in its implementation. With wider extra-billing by doctors, patients faced more out-of-pocket expenses and the concept of equal access to health care and comprehensive coverage, were being eroded (Naylor, 1982:13). Geographical concentration of doctors who extra-billed made the option of switching doctors unworkable for many patients. In some places, no opted-in specialists were available to serve patients who could not afford the extra fees.

During the same period, increasing concerns were being raised about two interrelated issues: overbuilding the hospital system and general underfunding of health care. Overbuilding the hospital system, it is argued, has led to extraordinary increases in expenditures (averaging 20 percent per annum, for example, in 1975 and 1976). These escalating costs are of concern to politicians, doctors and the public (Taylor, 1987:84-85). Paralleling this concern is the one that health care funding may be losing ground relative to other spheres. Once the medicare system was in place, so this argument goes, it was neglected as a priority for funding. What some doctors feel should be spent on increasing their insurance reimbursements was being spent in other areas. In short, the image of a health care cost crisis was being brought into public consciousness. A new element in all this was the growing conviction by many analysts of Canadian health care that the limits to a high technology, treatment oriented system of health care had been reached (Manga, 1987; Taylor, 1987:85). Doctors felt threatened by this concern too.

Increasing public debate eventually led the federal Liberal government to appoint in 1979 a special commissioner, Emmett Hall (the same man who had provided the groundwork for the medicare system in 1964), to conduct a public enquiry. The government had two basic questions: 1) were the provinces diverting federal health funds to non-health programs? and 2) were extra-billing by physicians and user charges violating the principle of reasonable access? (Taylor, 1987:87). The public responded with a total of 450 briefs that mainly approved of the system but also pointed out its shortcomings. The answer to the first question asked by the government was a clear no. As for the second question, Hall clearly saw extra-billing as a threat to health care accessibility as a right (Taylor, 1987:90). Hall suggested introducing binding arbitration to settle fee disputes between medical associations and provinces. According to Begin herself who was Minister of Health at the time, "it became evident that legislative action was the only route left to correct the situation" (Begin, 1986:89). The new Canada Health Act was passed into law on 9 April 1984.

The 1984 Act cut federal transfer payments to provinces by one dollar for each dollar doctors extra-billed their patients. The genius of the new Act is that it put tough controls on extra-billing but passed responsibility for enforcement to the provinces. Ottawa held the purse strings while the law went into effect slowly over a period of 2-3 years. Already in 1982 when the Act was only in proposal form, the Canadian Medical Association headed then by Marc Baltzan was preparing for a fight. In a letter written to 36,000 member doctors in 1982, Dr. Baltzan said that the proposed Act threatened the future of health care in Canada ("Doctors Prepared for a Fight" Kitchener-Waterloo Record, 20 November 1982). The stage was set for a confrontation years before the 1986 Ontario strike.

THE 1986 DOCTORS' STRIKE IN ONTARIO

The issues involved in 1986, although fresh in memory, became so highly convoluted as to be obscure to even to the most astute observer in the summer of 1986. However, in the context of this brief analysis of the history of medicare in Canada, the 1962 strike, the structure of medical practice and recent developments, the issues become more clear. The Province of Ontario had little choice in the extra billing dispute. The Province could not afford to forgo $50 million annually in health transfer payments from Ottawa to appease the wishes (rights) of a minority (12 percent) of doctors to extra-bill their patients. Thus, the passing of Bill 94 (the ban on extra-billing) was, in fact, inevitable. Why, then, did the Ontario Medical Association, take the action it did - closing doctors' offices, closing emergency departments and slowing down hospital discharges?

To some extent, the doctors were venting their anger at the government for perceived long-standing injustices, some of which have been outlined above. However, a few central themes emerge from the 1986 dispute which allow us a handle on the issues involved. These include the same themes discussed earlier with respect to the 1962 Saskatchewan strike - who knows best, control, ideology, power and focus of attention. In the 1986 strike, some of the issues are the same, others have new dimensions.

In 1986 in Ontario, the issues of who knows best about health care and the issue of control are inextricably bound together. Doctors, or at least their representatives in the Ontario Medical Association, believe that maintenance of their right to extra-bill patients allows them control over the way in which they practice medicine. When doctors repeatedly asserted in full-page advertisements in newspapers and in literature and posters in their offices, that the issue in the strike was not money, they were generally correct. Money, however, is related to the issue of control and who knows best, however. High status, which is directly related to high income, allows a freedom to decide not only what is best fo one's own profession, but allows those in a position of prestige to be listened to on what is best for society. Further, it is well-known in sociology that even within the medical profession, the more highly paid doctor will be taken more seriously by the patient. Doctor's orders are easier to follow if the doctor is better-off. We tend to be more suspicious of doctors who earn less and thus they can be more easily controlled. Doctors feared that with the banning of extra-billing, their control over their conditions of work was being eroded. They further saw Bill 94 as the edge of the future in government control over medicine by the state - hence, the rhetoric about doctors' becoming civil servants. Along with this perceived loss of control, doctors might lose some of their autonomy as a profession to decide for society what is best for them in terms of health care.

The facts seem to be that the Canadian public decided in the late 1960's and early 1970's with the advent of medicare in Canada that access to health care was to be a right with no financial barriers. Public opinion in every year since the introduction of medicare has been firmly and solidly in favour. In 1984, the Canadian Election Survey found some 75-90 percent of people in Ontario were against extra-billing (unpublished data, Canadian Election Survey). Further, in every dispute with the medical profession since, the resolution has been in favour of the government and the public rather than the doctors. Access to health care as a right among Canadians may erode doctors' autonomy, for what is generally seen as the public good. However, their control over the technological practice of medicine remains complete, as does their right to set their own hours, determine how many patients to see, where to practice, etc. The public and the government as a representative of the public, is deciding in only one realm - that of financial barriers to access - that it knows better than physicians. In this realm, physicians have lost some of their control, but it must be kept in mind in light of the history of medicare described earlier, that the right to extra-bill was not entrenched in medicare. In many ways, the Canada Health Act of 1984, only made clear what was previously ambiguous because of compromises rather than principles.

In terms of ideology, the issues involved in the 1986 strike are almost identical to those in the 1962 strike. Doctors' claimed in both disputes that their "freedom" was at stake. Essentially, the doctors saw, in both instances, the government as duty-bound *not* to interfere with their rights to practice medicine. Government alternatively, sees access to health care as a right which society has an obligation to provide to all. Thus, the rights of doctors come into conflict with the rights of the public. In this case the need principle takes precedence over the libertarian principle, or the freedom of individuals to get what they want. The greater good prevailed.

The power issue is an interesting one in the 1986 Ontario strike. Most analysts seem to agree that the Ontario Medial Association stood virtually no chance of winning the dispute with the government over Bill 94. Public opinion was strongly against extra-billing even two years before the strike, the public overwhelmingly favoured the medicare system. The Province of Ontario could not forgo $50 million annually. So why did the doctors assert their power in a highly contentious strike? In 1962, doctors felt that the government of Saskatchewan could be turned around, despite strong evidence to the contrary. In 1986 in Ontario, the concept of winning became more sophisticated. A victory for the doctors might include more say in the future in the negotiations of schedules, thereby reducing the need to extra-bill. It might include inducing fear in the government over taking any further liberties with doctors' autonomy. It might be simply a strong show of force which demonstrated to both the public and the government that doctors' services are vitally important. Lastly, it might be a means of demonstrating the power of collective consciousness among doctors who stood together, largely on this issue of extra-billing. Certainly it would be difficult to conclude that doctors unequivocably and totally lost in the dispute.

In terms of focus of attention, Ontario doctors in 1986 like those in Saskatchewan in 1962, came to be seen as being more concerned about their professional rights than with the rights of the public to health care. Doctors, although underlining their importance as health care providers by their strike action, also showed that in their power as a profession, they had some weaknesses. They were out of touch with public opinion and public need. They engaged more in consensual validation of their perspectives by talking to each other more openly than to patients. They failed to realize, perhaps due to lack of exposure to social science perspectives in university and medical school, that politics matters and that patients, in their awe and fear of medical practitioners, will do and say one thing in a doctor's office and quite another when voting or

expressing opinions to a pollster.

THE CENTRALITY OF HEALTH CARE ACCESS AS A RIGHT

The 1986 Ontario doctors' strike and the developments that lead to it highlight some important public health care issues in Canada. Clearly, doctors were fighting a battle that they lost in many respects. What did we learn and gain from the experience?

Medicare is clearly an enormously popular program in Canada. Its basic tenets of equal access, comprehensiveness, universality, public administration can only be violated at the political peril of those who tamper with it. Yet, medicare is not completely secure in Canada in the late 1980's. The infrastructure on which it rests was revealed as being highly political, the product of compromise, pressure and ambiguous settlement in both the long and recent past. Much of what occurs in the future with medicare, like so many other areas in Canada, will happen not because of the public will to change it but rather because of political machinery set in motion long ago including federal-provincial relations. The uneasy political equilibrium on which medicare is permitted will require an enormous expenditure of energy to maintain.

About the medical profession, we have learned once again that this is a very highly paid autonomous profession group whose services are essential to our well-being. In watching the limits to the power and autonomy of the medical profession, we have learned an extraordinary amount about their power and indispensability as well. The extent of their freedom to practice medicine also became fully visible in the 1986 strike, another paradox. The extent to which the public, the government and doctors themselves view medicine as an elite came clearly into focus in the summer of 1986. Doctors put on an impressive show of what some term petulance (McQuaig, 1986:7) without being legislated back to work, when some other less powerful, but no less essential, occupations and profession such as nurses, teachers, bus drivers, postal workers and garbage collectors are denounced as greedy but indispensable, and forced back to work. In ideological terms, the gap between the perspectives of doctors and those of the public emerged as fundamentally different. The strong free enterprise and libertarian orientation among the doctors provides an important contrast with the more collectivist, rights orientation among the Canadian public.

A fundamental, indelible lesson from the 1986 Ontario strike, however, is that the public in Canada, as indicated by the passage of the 1984 Canada Health Act, reaffirmed health care as a right. Health care for Canadians can never be again a privilege of the rich. Reassertion of this right in the face of opposition by a powerful profession, forces us as Canadians to the conclusion that health is a basic human need. In order for us to be granted the means to have this need meant, society must reconcile the sometimes conflicting needs of doctors and the public. Health care professionals are seen to have a societal and public duty to provide care, a duty that transcends the requirements of any profession, but one that should be an essential component of good medical practice.

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